Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SREENADHA VATTAM MD PYRAMID PAIN & REHAB PA 100 W LAMBERTH RD STE A SHERMAN TX 75092	MFDR Tracking #: M4-10-5133-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are hereby submitting the DWC060 for Medical Fee dispute resolution form for the claim # 149046164. The attached notes show that 2 lead implants were done. As per the American Medical association guidelines and HCPS guidelines regarding the implantable neurostimulator electrodes each lead has 8 electrodes and since we did 2 lead implants it amounts to 16 electrodes and has been billed accordingly, but the payment was paid only for 2 electrodes. We are requesting payment for remaining 14 electrodes which has not been paid. "

Amount in Dispute: $12,392.62

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Respondent did respond to the request for medical fee dispute resolution.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
05/11/10	L8680	$418.95 X 125% = $523.69 X 16 = $8,379.04 - $1,047.38 (carrier payment) = $7,855.35	$12,392.62	$7,855.35
			Total Due:	$7,855.35

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 06/22/2010:
   - 2 – (W1) Workers Compensation State Fee Schedule Adjustment.

   Explanation of benefits dated 08/04/2010:
   - 2 – (W1) Workers Compensation state Fee Schedule Adjustment.

Issues

1. Did the respondent correctly reimburse the requestor in accordance with Texas Administrative Code Section §134.203(d)?
2. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to Texas Admin. Code Section §134.203(d) HPCPCS Code L8680 is reimbursed at the DMEPOS fee schedule, plus 125%. The respondent reimbursed the requestor for 2 of the 16 electrodes billed; the requestor should have been reimbursed for all 16 electrodes used in the preauthorized spinal cord stimulator trial.
2. The requestor is entitled to reimbursement for the remaining 14 electrodes.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $7,855.35.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $7,855.35 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	10/20/10 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.